Los Angeles County Department of Mental Health
Pharmacy Services
2415 West Sixth Street, Los Angeles, CA 90057

CONTINUED TREATMENT AUTHORIZATION REQUEST FORM

Patient's Name: _____ MIS#: _____

Medication and Strength: _____ Date: _____

Primary Diagnosis: _____

Target Symptoms for Continued Treatment (Please check all applicable):

___ Psychotic Symptoms ___ Depressive Symptoms ___ Persistent Manic Symptoms
___ Anxiety Symptoms ___ Obsessive-compulsive symptoms

___ Other (Please Describe): _____

_____

_____

Degree of **overall improvement** with Authorized Treatment (please check one):

___ Complete ___ Significant ___ Slight ___ None

Degree of **symptom improvement** with Authorized Treatment (please check one):

___ Complete ___ Significant ___ Slight ___ None

Degree of **functional improvement** with Authorized Treatment (please check one):

___ Complete ___ Significant ___ Slight ___ None

Medical Justification for Continued Treatment (Please check all applicable):

___ Marked clinical improvement with authorized treatment

___ General medical condition(s) contraindicating other available medications (Please describe): _____

_____

___ Intolerable untoward effects with other available medications (Please describe): _____

_____

___ Improved patient compliance

Consequences of Non-approval (Please check all applicable):

___ Exacerbation of Clinical Condition

___ Absence of medically appropriate alternatives (Please describe reason): _____

___ Other (Please describe): _____

Requesting Physician: _____ **Telephone #:** _____

Clinic: _____

Approved by: _____ **Date:** _____

Duration of Approval: _____